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The status of public reporting of clinical outcomes in assisted reproductive technology

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TO THE EDITOR: We read the article ‘‘The Status of Public Reporting of Clinical Outcomes in Assisted Reproductive Technology’’ by Kushnir et al. (1) with great interest. As stewards of the National ART Surveillance System (NASS), we are always striving to improve data collection and public reporting of clinical outcomes of assisted reproduction, as required by the Fertility Clinic Success Rates and Certification Act (FCSRCA) of 1992. The article refers to the recent but increasing trend of short-term embryo banking—cycles in which all embryos are created with the intent of cryopreservation for subsequent transfer in frozen/thawed cycle(s) in the next few months—which has followed advances in cryopreservation techniques (2). Some of the potential reasons for delaying embryo transfer include embryo accumulation from several short-term embryo-banking cycles allowing a better choice of good-quality embryos, the desire to avoid potentially negative effects of stimulation on implantation/pregnancy rates and fetal development, and a need to wait for the results of preimplantation genetic screening. In contrast, long-term embryo-banking cycles are generally used for fertility preservation for patients who are undergoing gonadotoxic medical treatments or for those who wish to delay childbearing for other reasons. Although NASS is currently unable to distinguish between short-term and long-term banking cycles, we note that the total number and percentage of embryo-banking cycles in the United States has increased dramatically during recent years (Fig. 1).

Because FCSRCA requires public reporting of ART success rates, embryo-banking cycles (which by definition do not result in a clinical outcome) are not shown in the national or clinic-specific pregnancy success rate tables. However, all embryo-banking cycles fit the definition of ART and thus must be reported to the CDC. Thus, we believe that the authors incorrectly assumed that embryo-banking cycles are unreported or excluded by clinics. The outcomes of all frozen/thawed embryo transfers have been publicly reported for cycles started during or after 1995, the first year that national ART surveillance began. In addition, the reporting of embryo-banking cycles is validated annually (3).

We agree that with recent increases in embryo-banking cycles, concurrent changes in the information provided to consumers are warranted. For that reason, the 2011 ART Fertility Clinic Success Rates Report will include the number of embryo-banking cycles reported. Ideally, the outcomes of embryo-banking cycles would be reported both per cycle and per

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transfer, and separately for short-term and long-term embryo banking. This approach, however, would require the collection of additional information on cycle intent and/or on the linkage between embryo-banking cycles and subsequent frozen/thawed embryo transfer cycles, which often occur in different reporting years. Reporting the number of cycles using frozen/thawed embryos from previous transfer cycles and the number of short-term and long-term embryo banking cycles will inform potential ART consumers about differences in clinical practices and outcomes.

Public reporting on the clinical outcomes of ART has been providing useful information for ART providers, patients, researchers, and the general public for the last 16 years (4). The use of NASS data has contributed to improvements in the field and has made studies such as the one by Kushnir et al. (1) possible. That study serves as a reminder that the reporting of ART clinical outcomes needs to keep pace with rapidly changing clinical practice. We are considering revisions to the NASS data collection to better assess new methods and technologies and to include some of the measures we have described here.

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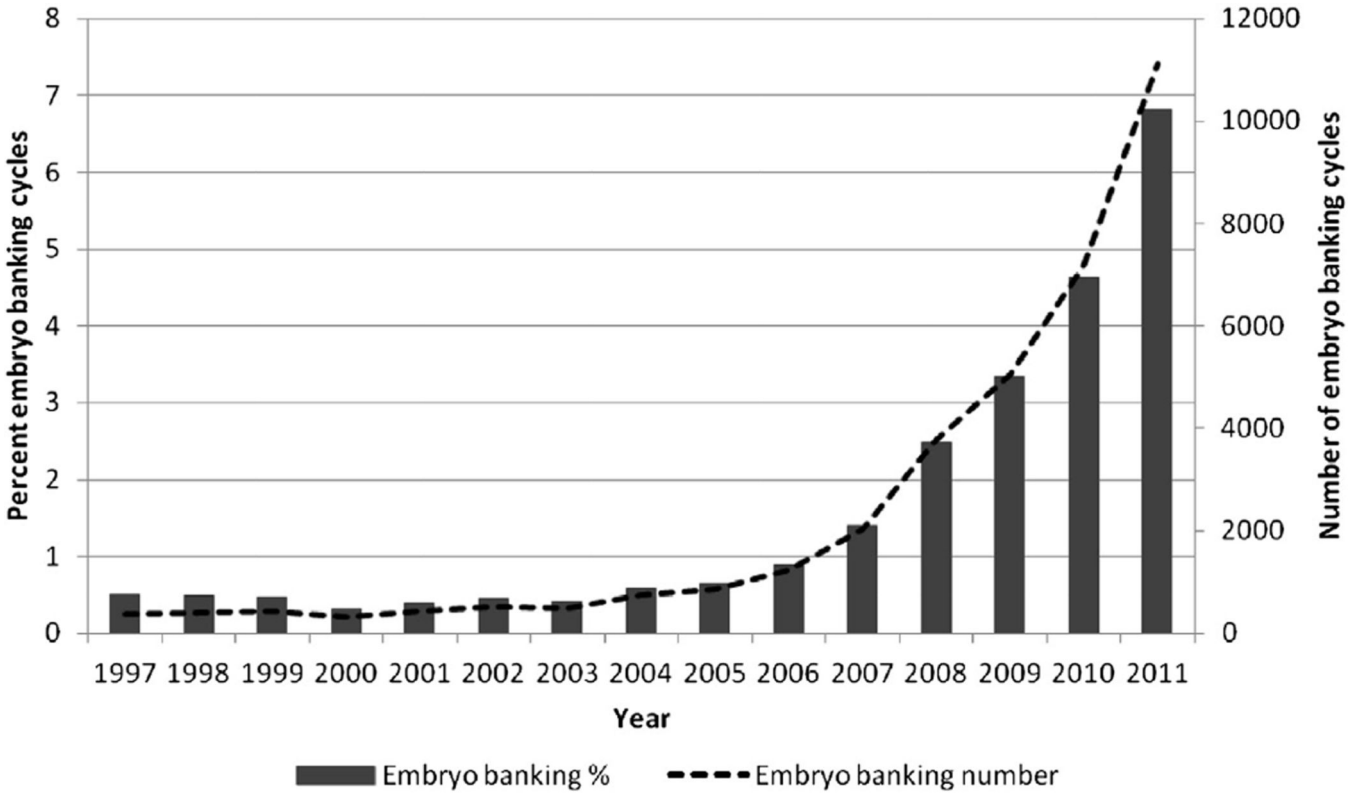

FIGURE 1.

Number and percentage of embryo-banking cycles among all ART cycles, National ART Surveillance System (NASS), United States, 1997–2011.

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